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AUTHOR Neilans, Thomas H.; And Others
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ABSTRACT

This paper describes the application of a systems approach model to assessing families with a labeled noncompliant child. The first section describes and comments on the applied methodology for the model. The second section describes the classification of 61 families containing a child labeled by the family as noncompliant. An analysis of data from the 61 families is discussed, which reveals that 4 district patterns account for 100% of the cases. Each of the four patterns, named after dances to reflect each particular pattern's own "beat" and repetitive structure, are labeled as the "Fox Trot," the "Rhumba," the "Tango," and the "Minuet" and discussed in detail. For each pattern, the number of families from each structure exhibiting the pattern is described along with the conceptualizations important for each pattern. The way that families frame their problem and their expectations for therapy are also discussed in the context of each dance pattern. (Author/NRB)

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Families With Noncompliant Children: Applications of the Systemic Model

Thomas H. Neilans

Kaiser-Permanente, Portland, OR

Barry Jacobson

Kaiser-Permanente, Portland, OR

Pamela Quataert

Edgefield Lodge, Troutdale, OR

Christine G. Glenn

Good Samaritan Hospital, Portland, OR

Richard J. Rosenberg

Edgefield Lodge, Troutdale, OR

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Running head: Applications of the Systemic Model

Families With Noncompliant Children: Applications of the Systemic Model

The systemic approach to family therapy has gained progressively wider acceptance among practitioners over the past decade. As is true with most new forms of therapy at their introduction, students of the systemic perspective have been largely occupied with the tasks of advancing theoretical knowledge and of developing techniques for assessment and intervention. To date, there has been little, if any, attention devoted to the work of operationalizing the conceptual base and conducting therapy outcome or process research. The present study represents such an effort.

The study had two basic aims: First, to implement the operationalized assumptions of systemic theory (our view of these assumptions and their operational corollaries is delineated in the first paper). This would enable the practitioner to schematize critical aspects of system functioning and thereby provide a useful assessment tool; second, to discover whether there exists sufficient similarity between the patterns of a number of families such that they could be classified. Such a classification might be an initial step toward developing systemic interventions which could differentially affect the various problem pattern types.

This paper will describe the application of our model to assessing families with a labeled noncompliant child. It will be divided into two sections. The first section will describe and comment on the

methodology of the study. The second will describe the classification of patterns of 61 families containing a child labeled by the family as noncompliant.

Methodology

It is our contention that the systemic approach can be applied effectively to any clinical population. We chose the subpopulation of families with noncompliant children for practical considerations. Both settings in which we work were established to provide therapeutic service for children and families. One is a private, nonprofit treatment agency which offers residential, day treatment, and outpatient services to "emotionally distressed" children ages 6 to 12. The other, the Family Intervention Program, is a child and family focused outpatient mental health program within a large health maintenance organization. Approximately 80% of the families with whom we worked in the first setting identified the primary problem as noncompliance in one or more of the children, while this was true for approximately 65% of the families in the second setting. Although the Family Intervention Program works with children of all ages, only noncompliant children ages 6 to 12 were used in the data collection. Another reason for focusing on families with a noncompliant child was that little or no literature exists on assessing this population from a systemic perspective.

Five therapists from the two agencies participated in the study. Two therapists worked only at the setting which offered residential, day treatment, and outpatient services. The other three therapists worked with families at both locations.

The first paper details the operational corollaries of our systemic approach to assessment which guided the process of data collection. Information was obtained on a total of 61 cases; 24 from the multi-setting institution and 37 from the Family Intervention Program. The presenting problem for each family was identified as well as whether the family was intact, blended, or single parent. A primary loop which included the presenting problem was identified. Each point on the loop described a specific behavior which one person in the family exhibited. If the therapist believed that a secondary loop was present it was also identified. It was possible to have more than one secondary loop. However, in each case, the therapist designated one loop as the primary loop. In addition to the identification information and the loop(s), each therapist delineated certain conceptualizations held by each member of the family. These included: (a) Conceptualization of himself/herself; (b) Conceptualization of each family member about other family members; (c) Conceptualization of the problem that s/he felt brought the family to therapy; and (d) Conceptualization of what each expected from therapy. Each therapist stated concisely the character of each conceptualization. The therapist was not expected to specifically direct the interview process toward actively collecting this information. Rather, the therapist was expected to generate the information from whatever happened in therapy. If the therapist believed that insufficient information was available to support each conceptualization, s/he did not do so.

In order to obtain some semblance of reliability among the therapists, all trained together and then collected reliability information on 20% of

the cases. Five cases were selected for training purposes. Audio tapes were made of the two initial sessions for each of the cases. Each therapist described a primary loop and conceptualizations for each case after listening to the two tapes. Discussion and feedback occurred following each case.

The 15 cases used to determine the reliability coefficient were randomly selected. For each of these cases the tape of the initial session was available, and for some cases tapes of the second session as well. Three or more therapists independently rated each case. Reliability was calculated by comparing only the primary loops. Each loop was considered to be either essentially focusing on the same pattern or not. Calculating agreements over agreements plus disagreements yielded a coefficient of 89%. It should be noted that we realize there are several difficulties in our method of collecting reliability but we felt some comment in this area was better than none. No reliability information was obtained for conceptualizations.

Before discussing the patterns we found, a few points regarding our method should be noted. Initially we found constructing the loops for families to be difficult. Our tendency to describe behavior using terms which implied causation was hard to resist. Phrases such as "mother uses inappropriate parenting" and "couple is unable to communicate effectively" infiltrated our work. We also attempted at first to include conceptualizations in the loops. Due to various difficulties with these approaches, it was decided that an objective description of a family member's behavior would serve as a point on a loop.

Regarding conceptualizations, we initially attempted to record each phrase emitted by a family member which appeared to fall within any of the conceptualization categories. Finding this too unwieldy, it was decided that each therapist would write a clear, concise summary of what s/he thought each family member's conceptualizations were. This method was much more useful.

Patterns for Families with Noncompliant Children

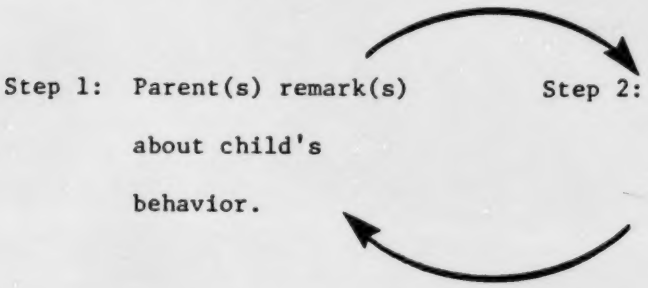
A careful analysis of the loop information for all 61 families after all the data had been collected revealed that 4 distinct patterns accounted for 100% of the cases. We have arbitrarily provided a label for each of these patterns. The patterns were named Fox Trot, Rhumba, Tango and Minuet. The names of dances were chosen to reflect each particular pattern's own "beat" and repetitive structure. Each of these patterns or dances in which the families were "stuck" will be discussed separately.

Before discussing each pattern, two points concerning our categorization should be mentioned. We initially attempted to organize families according to their structure; that is, single parent, blended, or intact. However, we found that the patterns were not categorizable according to family structure. Indeed, it was much more helpful to approach families therapeutically by focusing on the family's systemic pattern, not its structure. The second point is that we found certain conceptualizations to be more in evidence in some patterns than in others. However, the same conceptualizations were definitely present in different patterns. As each pattern is discussed, the number of families from each structure exhibiting the pattern will be described, as will be the conceptualizations that appear to be most important within each pattern. The way the

families framed their problem and their expectations for therapy will also be discussed in the context of each pattern.

Fox Trot

This pattern was named the Fox Trot because it essentially consists of a 2-step pattern which is in evidence at all times without much variation. The pattern looks like this:



Within Step 1 are included such behaviors as stating directions, discussing, yelling, rewarding, punishing, timing out, screaming, stating threats, stating concern, imitating, etc. Step 2 includes such behaviors as refusals, tantrums, yelling, screaming, discussing, imitating, etc. It should be noted that in this, as in all loops or patterns, there is no beginning or end. One behavior leads to a second behavior which leads to the first behavior which leads to the second, etc. We found that 23 of our cases fell into this first pattern: 10 single parent, 7 intact, and 6 blended. The overall quality of this pattern was that the majority of interaction between family members tended to be described by this loop. There existed little variation.

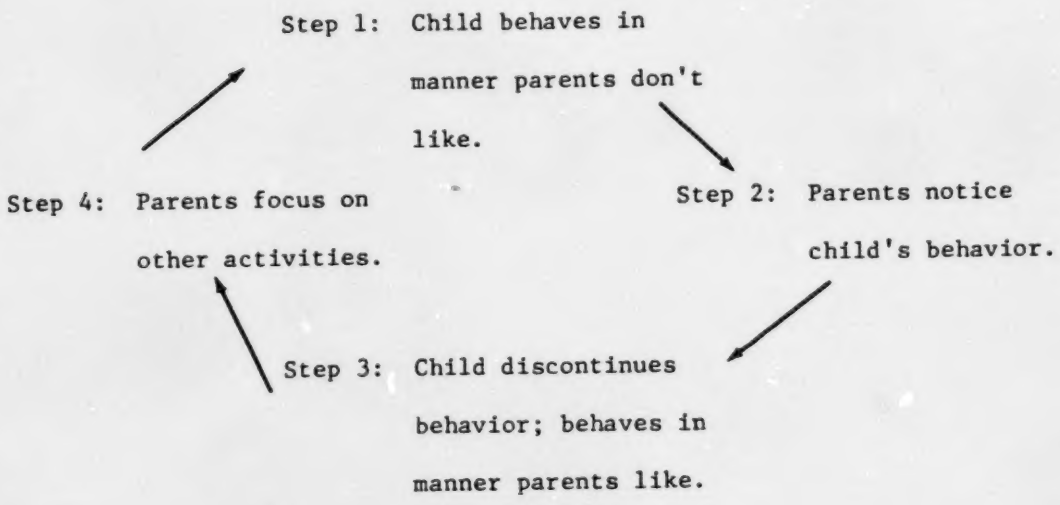
A general consistency existed in the conceptualizations for families which were included within this group. In regard to the problem, the parent(s) typically agreed, believing that the child was the problem,

that s/he had always had the problem, that quite possibly something early on had made him/her behave in such a way, and that they didn't understand the problem. Concerning therapy, the parent(s) felt the child needs help, the therapist should do something--either help them and/or fix the child, and that they need support. Regarding themselves, the parents felt they had done everything they possibly could, that they continually tried to help the child, that they were exhausted, and that they didn't know what else to do. The parents' view of the child was that s/he was always doing something wrong, that s/he is never good, that s/he is defiant, and that s/he is overactive or hyperactive. The child typically felt that the parents were often bugging him/her, that they were trying to boss him/her, and that they wouldn't give him/her a break. Usually a child felt there was no problem and hence therapy was not needed. Regarding him/herself the child felt s/he had always been this way and probably always would be.

The overall picture which can be drawn of this family from these conceptualizations is that of a family which has been stuck in an exhausting, repetitive pattern for several years without feeling good about any interactions. Typically, this pattern easily emerges in session, since the family knows few other ways of interacting. The arbitrary punctuation of the pattern by family members is clearly in evidence: the child wants the parents to stop bugging him/her while the parents want the child to stop bugging them.

Rhumba

As the Rhumba has components of the Fox Trot, this pattern includes the basic 2-step of the first pattern and adds an exciting 2-step addition which combines to form the 4-step pattern. This loop goes like this:


Step 1: Child behaves in manner parents don't like.
Step 2: Parents notice child's behavior.
Step 3: Child discontinues behavior; behaves in manner parents like.
Step 4: Parents focus on other activities.

Steps 1 and 2 essentially include all the behaviors that were mentioned for Steps 2 and 1, respectively, in the Fox Trot. Step 3 involves the child doing activities that the parents approve of: doing chores, playing quietly, watching TV, etc. Step 4 involves the parent(s) doing things concerning themselves or with each other: going to work, going out, worrying about their weight, talking to friends, talking to each other, fighting with each other, drinking, taking a nap, etc. Altogether, 14 cases fell into this category: 7 single parent, 4 intact, and 3 blended. Overall, these patterns usually showed more variety than those present

within the Fox Trot category. The families stuck in this pattern generally did not focus entirely on their child's "negative" behaviors but mentioned that they had positive time away or that they also had a problem: Step 4 involved either a focus on things the parents enjoyed (talking with friends, going out in the evening--at least attempting to go out, as their child often moved to Step 1 at this point) or a focus on things the parents considered problems for them (drinking, overeating).

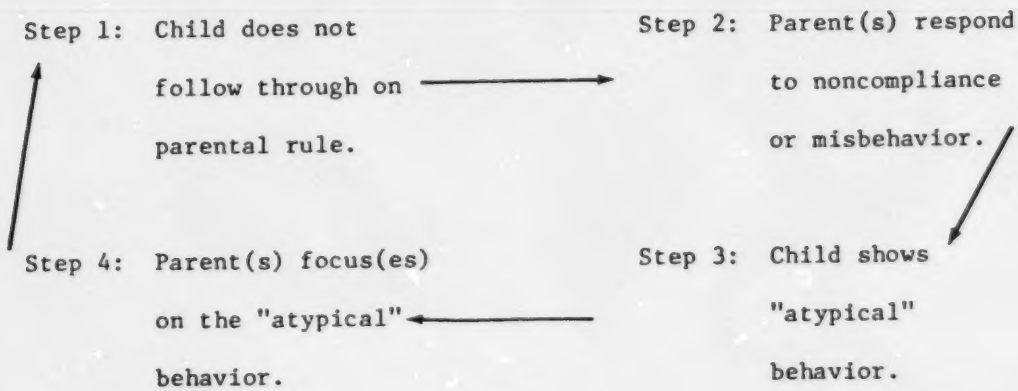
The conceptualizations of the family members generally had a more positive and hopeful quality about them; the family did not feel as overwhelmed as those in the Fox Trot. Similar to the Fox Trot, the parents were in general agreement in their views. The parent(s) felt that the child was a problem but that possibly they were also at least a part of the problem, that the child was too emotional or sensitive, and that the child was too easily upset and needed attention. Regarding therapy, the parents felt that therapy probably could help at least somewhat, that maybe they could use some therapy also (although the child should receive the therapy first and then the parent(s)), and the parents were not sure whether or not they might be able to solve their problem on their own. Their views of the child were that s/he is good some of the time, that the child needs to be loved, that the child should not be left alone, that s/he should not be punished too harshly, that they would rather give in than put up with the child's tantrums, and that the child should be able to be independent. The parents' views of themselves were that they should be more strict, that they often didn't try hard enough, and that they were concerned enough to at least

bring the child to therapy. The child views the problem as one that they (the parent(s) and s/he) have and that the problem occurs infrequently. Therapy is viewed by the child as an O.K. thing which may help all of the family members. The child views himself/herself as basically O.K. and considers that the parents are involved in too many other things (these other things may be construed as good or bad).

This pattern is less likely to emerge in session compared to the Fox Trot. The Rhumba is generally performed by relatively caring parents with a bright, verbal child. The family does not appear anxious for change. Indeed, families doing the Rhumba often seem to want to hear they do not have a problem.

Tango

The third pattern, labeled the Tango, has similarities to the first two patterns but the overall loop is quite different. There is much more strangeness or lack of syncopation and symmetry to this dance. It goes like this:


Step 1: Child does not follow through on parental rule.
Step 2: Parent(s) respond to noncompliance or misbehavior.
Step 3: Child shows "atypical" behavior.
Step 4: Parent(s) focus(es) on the "atypical" behavior.

Step 1 typically involves the child not doing a chore, avoiding a stated limit, or participating in an activity the parents have told him/her that s/he clearly should not do. The move by the parents, Step 2, involves responding to the noncompliance with "go to your room," a restatement of the rule, removing the child bodily from the situation, or stating some consequence. In Step 3 the child sidesteps on a downbeat; the child shows some particular type of behavior which seems out of the ordinary to adults. This may involve such behaviors as setting fires, extreme agitation, suicidal statements, excessive worry, or depression. Also it may involve much less noticeable behaviors such as crying, going to room, or reporting unhappiness. The parental response in Step 4 stays in rhythm; the parent(s) focus(es) on the "atypical" behavior with such moves as bringing the child to therapy, showing great concern for the child, talking to the child therapeutically, or discussing their "problem child" with each other or with helpful neighbors. In those cases where the child does not move with bravado in Step 3, the parent(s) focus on a previous incident that must be causing the child distress. Examples would be a divorce, a remarriage, abuse by one parent at some time, or an earlier traumatic experience. Of the 61 cases, 14 fell into this pattern with 7 in single parent families, 4 in intact families, and 3 in blended families.

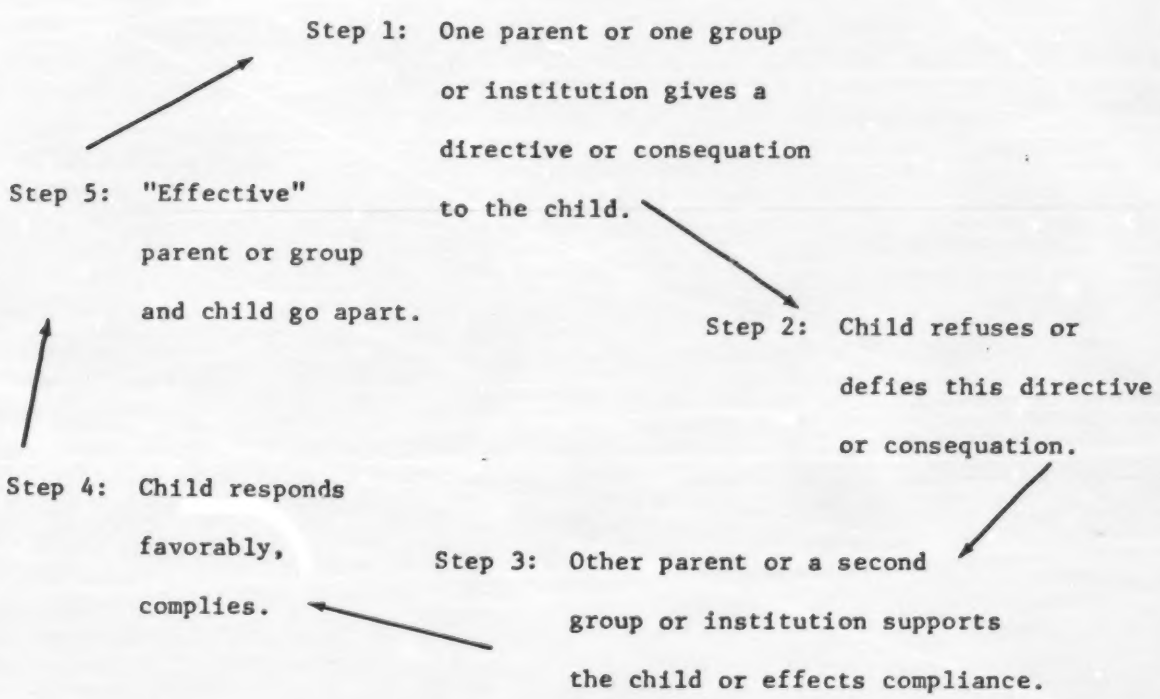
As in other categories, there existed a general consistency to the conceptualizations of the family members doing the Tango. Parents typically view things similarly. Their view of the problem was that the child had deep-seated anger inside, that the natural father didn't see the child enough, that the child puts too much pressure on him/herself

and is depressed, or that the child has problems due to changes in the parents' lives, earlier abuse, or a "bad home situation." They believed that the therapy would give them some understanding or insight into the child's problem, that therapy would determine how deviant or "sick" the child really was, or that their child should see an expert who could fix their child, probably through serious individual therapy. Consistent with their view of the problem and therapy, they thought that the child was troubled, confused or damaged, that they needed to worry about the child and that the problem was not the child's fault. The parents viewed themselves as warm and understanding, that they needed to make up for earlier "damage" inflicted, and/or that they felt guilty about what had happened to their child previously. The parental conceptualizations clearly indicate the impetus behind the move to Step 3 after Step 2. The child viewed the problem as, if anything, the parents not letting him/her do what s/he wanted to do. Therapy was typically viewed as something to put up with but useless. The child viewed him/herself as one to do what s/he wanted, to not know at times what would cause him/her to act as s/he does, or to get depressed or sad at times. Distinct views of the parents did not seem to be in evidence.

Seldom would the actual dance present itself in session. Typically, the family would be in Step 4 of their dance which, indeed, often was the act of coming to therapy. Families doing the Tango seemed concerned about their child but from a distance, as if there was something strange about their child.

Minuet

The Minuet seems to accurately reflect the quality of this fourth and final pattern. This pattern is quite complex; it can involve several different dancers, and the dancers that participate often maintain quite a bit of distance from each other even though they are in step with each other. The pattern goes like this:


Step 1: One parent or one group or institution gives a directive or consequation to the child.
Step 2: Child refuses or defies this directive or consequation.
Step 3: Other parent or a second group or institution supports the child or effects compliance.
Step 4: Child responds favorably, complies.
Step 5: "Effective" parent or group and child go apart.

Step 1 typically involved one of the parents (in blended families it was usually the step-parent; in intact families the mother; and if institutions were involved, the school.) stating a request, suggestion, directive, or command that the child do something, or be consequated for some behavior. The child's response in Step 2 was to refuse the directive or defy the

consequation with various accompanying moves of tantruming, yelling, fighting, etc. At this point (Step 3) the other parent or a second group (the child's family may be this group if the school performed Step 1 or it may be one of two households for children that reside in two) supports the child and states compliance messages of their own. The child, in Step 4, responds just as the second parent or group would wish. Then in Step 5, the step just before Step 1, the parent that was able to effect compliance and the child separate. In the case of an in-family dance, the parent may leave the house. In the case of a between-groups dance, the child may leave school or leave the one family to visit or stay with the other family.

Eleven cases fell into this category, 6 invoving blended families and 5 involving intact families. In three of the cases the dance was between the family and a school. The other cases danced within the family. No single parent families were present in this group. It was understandable that the within-family Minuet could not be performed by a single parent family but the between group Minuet could have been performed. The fact that no single-parent families and that only 3 blended or intact families danced the between-groups Minuet with schools as their partner may reflect the fact that the multi-setting institution has its own school and that data from the Family Intervention Program was collected during late spring and summer. The Minuet was not allowed to be danced at the former institution (at least for children in residence and day treatment) and it is unusual for "school problems" to occur in late spring and summer.

The conceptualizations in the Minuet are clear. Only the conceptualizations that accompany the in-family Minuet will be presented here. The same conceptualizations can be applied to the between-groups Minuet except the names of the partners change. In this dance the two parents do not exhibit similar conceptualizations. The "effective" parent views the problem as having to do with the relationship between the other parent and the child, or that the other parent is the problem. Therapy is viewed as being necessary to fix the problematic relationship or the other parent's ability to take care of the child and to show that the other parent is at fault. The effective parent views himself/herself as doing O.K. and able to handle the child. S/he views the ineffective parent as too lenient or incompetent. The child is felt to be coping as best s/he can and needing support from the effective parent. The ineffective parent feels the child is the problem or that the lack of support the ineffective parent receives from his/her spouse is the problem. Therapy should involve fixing the child, removing him/her from the home, or showing that the ineffective parent is right and the other parent is wrong. The ineffective parent views himself/herself as wronged, overwhelmed, and unsupported; views the child as "out to get him/her" and as two-faced; and views the effective parent as unsupportive and possibly too strict. The child has no strong views regarding therapy. Typically s/he feels the ineffective parent is the problem. The child's views regarding the other family members are definite: The effective parent is good and nice to be around; the ineffective parent is bad and terrible to be around. The child feels that s/he would be

much better off in his/her life if the ineffective parent were not around.

As was the case for the Fox Trot, the therapist is likely to quickly observe this pattern emerge in session. The general style of interaction in this dance is to take sides and fight. The potential clearly exists for the therapist to be drawn into the struggle. The fabric of interaction focuses on how poorly someone else does in sundry situations.

Concluding Remarks

This paper has focused on our methodology for the assessment of noncompliant families and on describing the four patterns which were found to occur. Little was said about how one proceeds to intervene with these patterns since this was not the focus of this paper. Our intention, however, is to systematically approach intervening in each of these patterns within the assumptions of our systemic approach. Preliminary findings indicate the systemic approach is useful in orchestrating effective interventions with noncompliant families as well as with the assessment of them.